



Child and Adult Care Food Program (CACFP)

Recordkeeping Requirements

for the

At-Risk After School Snack and Supper Program

Missouri Department of Health and Senior Services
Division of Nutritional Health and Services
Bureau of Community Food and Nutrition Assistance
P.O. Box 570
Jefferson City, MO 65102-0570
800-733-6251
FAX 573-526-3679

October 2002

Missouri Department of Health and Senior Services
Child and Adult Care Food Program

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Healthy Eating After School

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Alternate forms of this publication for persons with disabilities may be obtained by contacting the Missouri Department of Health and Senior Services, Bureau of Community Food and Nutrition Assistance, P.O. Box 570, Jefferson City, MO 65102, 1-800-733-6251. TDD users can access the preceding number by calling 1-800-735-2966. EEO/AAP services provided on a non-discriminatory basis.

Missouri Department of Health and Senior Services
Bureau of Community Food and Nutrition Assistance
Child and Adult Care Food Program Offices

Central Office

P.O. Box 570
Jefferson City, MO 65102-0570
800-733-6251
FAX 573-526-3679
Contacts: Susan Friese

Northwest District Health Office

13901 Noland Court
Independence, MO 64055
Contact: Dana Troxel

Cape Girardeau Area Health Office

710 Southern Expressway, Suite B
Cape Girardeau, MO 63703
Contact: Debra Birkman

Southwest District Health Office

1414 W. Elfindale
Springfield, MO 65801
Contact: Susan Barr

Eastern District Health Office

220 South Jefferson
St. Louis, MO 63103
314-877-2852
Contacts: Tammy Hamilton and Tracy Reese Okosi

Who is eligible to participate?

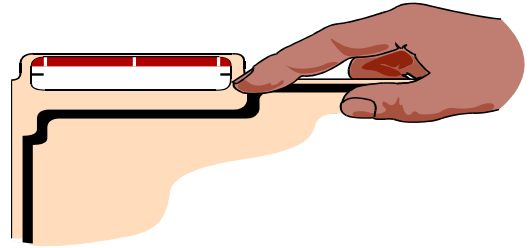
Eligibility Requirements:

To be eligible to qualify for reimbursement under the Child and Adult Care Food Program, after-school programs must meet the following criteria:

- ♦ The program must be operated by a public or private non-profit organization. In some instances, for-profit organizations may also be eligible to participate in the program.
- ♦ The program must operate in an after-school setting.
- ♦ The after-school program must provide an organized, structured, supervised environment which includes educational or enrichment activities. Programs offering supervised athletic activities along with education or enrichment activities may also be eligible, however, the athletic activities must be open to all and may not limit membership for reasons other than space, security or licensing requirements.
- ♦ The after-school program must be located in a geographic area where at least 50% of the children enrolled in the school serving the area are eligible for free or reduced price school lunch meals.
- ♦ The program must be licensed, or must provide certification that the facility meets minimum health and safety standards, including a copy of a recent fire safety inspection, and a copy of a recent sanitation inspection.
- ♦ Reimbursement may only be made for snacks and/or suppers served to children after the school day has ended. Before school snacks or snacks served during the course of the school day, i.e., as part of a kindergarten or preschool program, are not eligible for reimbursement under this program.
- ♦ If both a snack and supper are served in the after-school program, a total of three hours must elapse between the start of the snack and the start of the supper meal.
- ♦ Snacks and/or suppers served on weekends, holidays, and other vacation periods during the regular school year are eligible for reimbursement.
- ♦ The after-school snack and supper program is only available during the months that school is in session. Summer programs do not qualify for reimbursement under this program.
- ♦ Reimbursement may only be made for children between the ages of 1 and 18. If a child reaches his or her 19th birthday after the start of the school year, the child will remain eligible for snack and supper reimbursement through the remaining school year. Reimbursement may also be claimed for individuals who are mentally or physically disabled, regardless of age.

Recordkeeping Requirements

What Do I Have to Do?



Our goal is to keep any recordkeeping burden to the minimum necessary to ensure that Child and Adult Care Food Program (CACFP) reimbursement is properly paid. New participants will attend an orientation workshop within the first 45 days of participation in the CACFP.

Each after school program will be monitored at least every four years. The program will receive official notice two weeks in advance. During monitoring visits, at least one meal service will be observed. All required records (listed below) must be available to the Department representative within one hour of arrival. Failure to make any and/or all records available within the required time may result in findings, corrective action, and/or overclaims.

- ❑ Current license or copies of recent fire safety inspection and sanitation inspection.
- ❑ Enrollment roster.
- ❑ All application materials and supporting documents submitted to Missouri Department of Health and Senior Services (MDHSS).
- ❑ Copy of the sanitation inspection.
- ❑ Attendance and meal tally records.
- ❑ Menus that meet the minimum requirements. (CACFP Meal Pattern for Snacks and Suppers*)
- ❑ Non-profit food service verification: copies of invoices and receipts that document labor costs, operating costs, and income to the program.
- ❑ Yearly report of the racial/ethnic breakdown of participating children on the Beneficiary Data Form*.
- ❑ Copies of Claims for Reimbursement submitted to MDHSS-CACFP.
- ❑ Receipts for all CACFP payments and records of deposit for the CACFP reimbursement check. Reimbursements can be directly deposited to your account by completing the Vendor Automated Clearing House Application in this booklet.
- ❑ Documentation of yearly training to staff on Master Training Log or CACFP Training Documentation.
- ❑ An audit report for the most recent year if your institution receives more than \$300,000 per year in federal funds.
- ❑ A copy of the "And Justice for All" poster, posted in a prominent place to comply with 1964 Civil Rights Act.

Reimbursement

How Much Will I Receive?



After-school programs may claim reimbursement for one snack and/or one supper, per child, per day. The reimbursement rate for snacks and suppers served to participating children for the period July 1, 2002 through June 30, 2003 is:

Snack

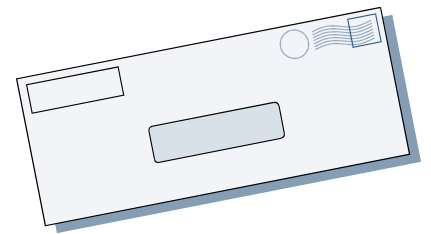
\$0.58

Supper

\$2.2925

Claims Submission

How Do I Get Paid?



A monthly Claim for Reimbursement must be submitted to MDHSS-CACFP within 60 days from the last day of the claim month. To receive timely payment, claims must be received by MDHSS-CACFP by 5:00 PM on the 10th of the month for the first processing. You may fax your claim to 573-526-3679 by 5 PM on the 10th of the month. Claims received after the 10th of the month will be processed in the second processing. Second processing claims must be received by the 25th of the month. All documentation used for compiling the claim must be kept for a period of three years after the end of the fiscal year to which they pertain.

Tips for organizing your records

- Choose a file box or cabinet to store your records safely.
- Purchase file folders, large envelopes and a 3-ring binder.
- Make copies of the Attendance and Meal Tally to keep in a folder or binder.
- List all enrolled children on the Attendance and Meal Tally. Add to the list as children join your program.
- Complete the meal count at each snack as the children are being served.
- Keep all food service cost receipts, invoices, etc. in a file or envelope by the month of purchase or donation.
- Label another folder for Menus. File all your menus for the month.
- Label another file or folder for production records for the foods served children for all snacks.
- Label two file folders for claims: Blank Forms and Completed Forms.
- Place preprinted labels on both the white and yellow copies of claim forms.
- Between the 1st and 5th day of the month following your first month on CACFP, follow the steps in this booklet for completing your Claim for Reimbursement.

Content of Meals

What should I serve?

Snacks and suppers served must meet the meal pattern for snacks (see meal pattern chart below) under the CACFP. It is recommended that programs offer larger portions for older children (aged 13 through 18) based on their greater food energy requirements.

Meal Pattern for Supper

S U P P E R		Children age 5 and under	Children age 6 through 18
	Milk, fluid	3/4 cup	1 cup
	Meat, poultry, fish, or Meat alternate ¹	1 ½ ounces	2 ounces
	Cheese (natural or processed) or	1 ½ ounces	2 ounces
	Egg or	1	1
	Yogurt (lowfat or nonfat) or	¾ cup	1 cup
	Cooked dry beans or peas or	3/8 cup	½ cup
	Peanut butter, soy nut butter, or	3 Tablespoons	4 Tablespoons
	Peanuts, soy nuts, tree nuts or seeds	1 ½ ounces	2 ounces
	Juice, fruit or vegetable ² (serve two types)	½ cup total	¾ cup total
	Bread, enriched or whole grain or	½ slice	1 slice
	Cornbread, muffins, rolls, or biscuits, or	½ serving	1 serving
	Cereal, enriched or whole grain (cold, dry) or	1/3 cup or ½ oz.	¾ cup or 1 oz.
	Cereal enriched or whole grain (hot, cooked) or	¼ cup	½ cup
	Rice or Pasta	¼ cup	½ cup

¹Meat alternates include cheese, egg, cooked dry beans or peas, nuts, nut & seed butters.

²Must serve at least two different types of fruit and/or vegetables.

Meal Pattern for Snack

	Choose two of four components	Children age 5 and under	Children age 6 through 18
S			
N	Fluid Milk	½ cup	1 cup
A	Juice or fruit or vegetable ³	½ cup	¾ cup
C	Meat or meat alternate	½ ounce	1 ounce
K	Grains/bread	½ slice or equivalent	1 slice or equivalent

³Juice may not be served if milk is the only other component at snack. Juices must be 100% fruit or vegetable juice.

Snack and Supper Menus

Meal Pattern for Snack Choose two of four components	Date:	Date:	Date:	Date:	Date:	Date:	Date:
Milk (fluid)							
Juice* or fruit or vegetable							
Grain/bread							
Meat/meat alternate							
Meal Pattern for Supper	Date:	Date:	Date:	Date:	Date:	Date:	Date:
Milk (fluid)							
Fruit or vegetable**							
Fruit or vegetable							
Grain/bread							
Meat/meat alternate							

*Juice may not be served when milk is the only other component of the snack.

**Serve at least two different varieties.

After-school programs may claim reimbursement for snacks served on weekends, holidays, and other vacation periods during the regular school year. Programs may not claim reimbursement through this provision when school is not in session (i.e., when school is closed for the summer).

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Daily Menu Planning and Production Record

Date	Meal	Menu	Number to be served	Food items used	Amount prepared or served

Menu Checklist:

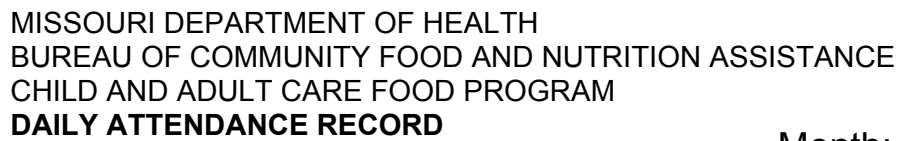
1. Does each snack contain at least two components, each from a different food group?
2. Have you been very specific about the type of item to be served and how it is prepared?
3. Have you been specific about the package sizes and/or weight of food prepared.

Daily Menu Planning and Production Record

Date	Meal	Menu	Number to be served	Food items used	Amount prepared or served
9/10	Supper	Baked Fish Fillets Macaroni and Cheese Green Beans Peach Slices Milk	40	Fish Macaroni Green Beans Peaches Milk	2.5 pounds 2 pounds 1 #10 can 2 #10 cans 40 ½ pints
9/10	Snack	Blueberry Muffins Apple Juice	65	Muffins Apple Juice	65 – 3 ounce muffins 5 – 64 ounce cans
9/11	Supper	Hamburger on a bun French Fries Mixed Fruit Cup Milk	35	Ground beef patties Frozen French Fries Fruit Cocktail Buns Milk	35 – 3.2 ounce patties 10 pounds 2 #10 cans 3 – 16 ounce pkgs. 35 ½ pints
9/11	Snack	Cheerios Milk	55	Cheerios Milk	3 – 24 ounce boxes 55 ½ pints

Menu Checklist:

1. Does each snack contain at least two components, each from a different food group?
2. Have you been very specific about the type of item to be served and how it is prepared?
3. Have you been specific about the package sizes and/or weight of food prepared.

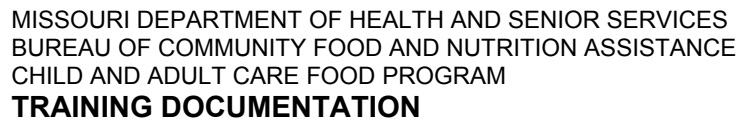


Month: _____

[illegible]

Meal Count Record

Name of Program								Date			Meal Served SNACK SUPPER			
Meals Left from Previous Day					Meals Prepared/Delivered					Total Meals Available				
Meal Tally (make a slash mark through the numbers for each meal/snack served.)														
1	11	21	31	41	51	61	71	81	91	101	111	121	131	141
2	12	22	32	42	52	62	72	82	92	102	112	122	132	142
3	13	23	33	43	53	63	73	83	93	103	113	123	133	143
4	14	24	34	44	54	64	74	84	94	104	114	124	134	144
5	15	25	35	45	55	65	75	85	95	105	115	125	135	145
6	16	26	36	46	56	66	76	86	96	106	116	126	136	146
7	17	27	37	47	57	67	77	87	97	107	117	127	137	147
8	18	28	38	48	58	68	78	88	98	108	118	128	138	148
9	19	29	39	49	59	69	79	89	99	109	119	129	139	149
10	20	30	40	50	60	70	80	90	100	110	120	130	140	150
Adult Meal Tally														
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Total Meals Served to Eligible Participants										_____				
Total Meals Served to Adults										_____				
Total Meals Left Over										_____				
Signature of After-School Program Representative										Date				



Attendance Sign-In

CACFP-222

Documenting Staff Training

Staff must be trained at least annually with regard to the CACFP. Update staff on any changes that occur during the year. Documentation of training must include:

- a) topics
- b) session dates
- c) number in attendance
- d) location
- e) names of participants (attach a sign-in sheet or roster)
- f) name of presenter

The Master Training Log or the Training Documentation form may be used to document the annual CACFP training you conduct.

Documenting Non-Profit Food Service

Programs must have documentation to verify that all of the CCFP reimbursement is being used solely for conducting or improving the food service operation. Non-profit food service verification includes:

1. Save all food and nonfood receipts or invoices. Nonfood costs can be charged to the food service if the nonfood product is necessary to the food service. Examples of allowable nonfood charges include paper napkins, straws, plastic utensils, cleaning supplies for the kitchen, etc.

Only those foods used for the CACFP can be charged to the food service. Food items purchased strictly for adults or for other programs cannot be counted toward the CACFP food service costs.

2. Determine the total amount of food and nonfood costs. If this amount is less than the CACFP monthly reimbursement, document food service labor costs. If the amount of food cost for the month is greater than the CACFP reimbursement, the center does not need to document labor costs.
3. Determine the amount of labor spent on the food service. The Labor Costs form, below, will assist in determining how much labor cost can be charged to the food service. Each position used for the food service shall be listed. For each position listed, indicate:
 - a) The salary per hour
 - b) The number of hours spent on the food service
 - d) The total cost chargeable to the food program

Labor cost charges must be supported by payroll stubs and time studies.



SUMMARY OF SALARY EXPENSES

MO 580-1458 (9-01)



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF COMMUNITY FOOD AND NUTRITION ASSISTANCE
CHILD AND ADULT CARE FOOD PROGRAM
BENEFICIARY DATA REPORT

A Beneficiary Data Report must be completed once a year to report the racial/ethnic category of participants enrolled in your center. Determine the participant's racial/ethnic category visually using your best judgement. A participant may be included in the category to which he or she appears to belong, identifies with, or is regarded as a member of by the community.

NAME OF CENTER/FACILITY:

ADDRESS:

Racial/Ethnic Category	Number of Participants
Alaskan Native or Native American – A person having origins in any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition (includes Aleuts and Eskimos).	
Asian or Pacific Islander – A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands, and Samoa.	
Black (not of Hispanic origin) – A person having origins in black racial groups of Africa.	
Hispanic – A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.	
White (not of Hispanic origin) – A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.	
SIGNATURE OF DIRECTOR 	DATE

Filing a Claim for Reimbursement

A center has 60 calendar days from the end of a claim month to submit a claim for reimbursement. If a claim is postmarked more than 60 days past due, the center may not be paid for that month.

Mail the completed claim form after you have reviewed your entries and are satisfied that the claim is completed accurately. Allow a minimum of 3 days for the claim form to reach the MDHSS. Claims may be faxed to (573) 526-3679, but must be legible or they will be returned for correction.

MDHSS processes claims on the 10th of each month for payment by check or automatic deposit by around the 28th of the month. A second processing for claims is done on the 25th of the month for claims received the 11th through the 25th. The second payment is made around the 13th of the following month.

DHSS Receives Claim by:

10th of the month

25th of the month

Projected Check Issue Date:

28th of the month

13th of the next month

If you receive payment by check, please allow several days for mail delivery. If you have not received your check within 15 days of the payment date, please contact DHSS to determine if there were problems with the claim or check.

Things To Do

- ✓ Place contract number label on the Claim for Reimbursement forms.
- ✓ Between the 1st and 5th day of the month, follow the steps outlined in the booklet and complete your Claim for Reimbursement form.

Common Errors

1. Label with center name and address are missing from the form.
2. Labels are from a previous contract year.
3. Period covered by the claim is more than one month.
4. Total Meals (Line 12) is not completed.
5. Addition is incorrect.
6. Section 7 and section 12 incorrectly lists the exact same numbers. Section 7 is the total number of kids present for the month and section 12 is the total number of meals served by type, per month.
7. Meal claims are in excess of enrollment and/or attendance.
8. Form is not dated and signed.
9. Unauthorized person signed the form.

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MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF COMMUNITY FOOD AND NUTRITION ASSISTANCE
CHILD AND ADULT CARE FOOD PROGRAM

FAX # 573-526-3679

PO BOX 570

JEFFERSON CITY MO 65102-0570

CLAIM FOR REIMBURSEMENT

READ INSTRUCTIONS ON REVERSE SIDE CAREFULLY BEFORE COMPLETING CLAIM.

1. NAME AND ADDRESS OF INSTITUTION. PLACE PREPRINTED LABEL HERE.	2. CLAIM MONTH/YEAR ____ / ____	3. ORIGINAL ☐	4. REVISION ☐ 1 ST ☐ 2 ND ☐ 3 RD
5. PERIOD COVERED BY CLAIM (COMPLETE ONLY WHEN CLAIM INCLUDES 10 OPERATING DAYS OR LESS IN THE PRIOR MONTH AND/OR 10 OPERATING DAYS OR LESS IN THE FOLLOWING MONTH.) START DATE _____ END DATE _____		6. TOTAL NUMBER OF DAYS IN CLAIM PERIOD DURING WHICH MEALS WERE PROVIDED	
7. TOTAL NUMBER OF ALL PARTICIPANTS IN ATTENDANCE FOR ALL DAYS DESIGNATED IN BOX 6 ABOVE		8. NUMBER OF CENTERS THIS CLAIM PERIOD FOR WHICH YOU ARE CLAIMING MEALS	

TOTAL NUMBER OF MEALS SERVED TO PARTICIPANTS IN DAY CARE CENTERS.

	A. BREAKFASTS	B. LUNCHES	C. SUPPERS	D. SNACKS	13. ENROLLMENT
9. FREE					
10. REDUCED					
11. PAID					
12. TOTAL					

COMPLETE ONLY IF YOU HAVE APPROVED AT-RISK SITES.

14. AT-RISK:	A. ATTENDANCE	B. OUTLETS	C. SUPPERS	D. SNACKS
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15. ELIGIBLE NUMBER IN FOR-PROFIT CENTERS

NAME OF CENTER(S)	TOTAL ENROLLMENT FOR CLAIM PERIOD OR LICENSED CAPACITY (whichever is less)	ELIGIBLE TITLE XX OR TITLE XIX PARTICIPANTS OR FREE/REDUCED ELIGIBLE

16. REMARKS

I CERTIFY that to the best of my knowledge and belief, this claim is true and correct in all respects, that records are available to support this claim, that it is in accordance with the terms of existing Contract(s); I recognize that I will be fully responsible for any excess amounts which may result from erroneous or neglectful reporting herein. I further certify that claims submitted for meals served in for-profit Title XX or Title XIX centers are submitted for those centers having 25% or more participants receiving Title XX or Title XIX benefits or free/reduced eligible enrolled for this claim period or 25% or more of licensed capacity were receiving Title XX or Title XIX benefits or free/reduced eligible for this claim period. I further certify that all claims for reimbursement shall be submitted to the Missouri Department of Health and Senior Services no later than the legislatively mandated deadline of 60 days after the end of the claim month. I understand that failure to submit claims within the 60 day deadline may result in such claims not being paid.

17. SIGNATURE OF AUTHORIZED REPRESENTATIVE ▶	18. TITLE	19. PREPARATION DATE
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THIS SPACE IS FOR MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES CACFP ONLY.

DEPARTMENT CACFP AUTHORIZED SIGNATURE ▶	DATE
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All records supporting the claim for reimbursement must be retained and available for future audit for a period of 3 years and the current year. No further monies or other benefits may be paid out under the Program unless this report is completed and filed as required by existing regulations (7 CFR 226).

Check original claim if claim is first for the billing period. If claim must be revised later for same billing, check "Revision" block.

INSTRUCTIONS

SPECIAL NOTE: A REVISED CLAIM completely voids all previous claims for the same month. Therefore, include ALL reporting data for the entire month's operation. Also, be certain to maintain all pertinent records and adequate documentation to support the claim for reimbursement.

GENERAL

Report data for one calendar month only. If the first or last month of operation contains 10 working days or less, such a month may be added to the claim for the appropriate adjacent month. However, DO NOT combine on any claim September meal service information with October meal service information. Your amount of payment will be computed by Community Food and Nutrition Assistance (CFNA) based on the United States Department of Agriculture (USDA) meal reimbursement rates.

This claim will be returned and payment cannot be made if claim is not properly completed. Therefore, sign and date this claim before mailing it to CFNA. If you have any questions about how to complete this form, please contact CFNA for assistance.

Submit the claim to CFNA. All claims must be received in our office by the 10th of the month following the claim month (first processing cycle) or the 25th of the month following the claim month (second processing cycle). The institution must make a copy of the claim before submitting. Keep the copy for your files.

All claims for centers must include entries for items 1-13 and 17-19. Items 5, 14, 15, and 16 must be completed if appropriate.

Send or fax claims to:

**Missouri Department of Health and Senior Services
Bureau of Community Food and Nutrition Assistance
P.O. Box 570
Jefferson City, MO 65102
Fax # 573-526-3679**

REVIEW YOUR ENTRIES. WHEN YOU ARE SATISFIED THEY ARE TRUE AND CORRECT TO THE BEST OF YOUR KNOWLEDGE, SIGN THE REPORT, AND ENTER YOUR TITLE AND DATE REPORT WAS PREPARED.

SPECIFIC INSTRUCTIONS

ITEM

1. Check to be sure the pre-printed information is correct. If the contract number or center name and address are missing, please put in the proper information. If either or both are incorrect, immediately contact CFNA to make corrections.
2. Enter the month and year that this claim covers. For example, January 2002 would be entered as:

01 02
- 3 & 4. Enter if original or revised claim.
5. Complete only if claim includes 10 operating days or less in prior month or 10 operating days or less in following month. Please note that a claim **cannot** combine September/October program information.
6. Enter the actual number of days you served meals to participants as part of the Child and Adult Care Food Program.
7. Compute total attendance by adding daily center attendance (not meal counts) for each day of the claim period.
8. Enter the number of centers in operation for this claim period.
- 9-11. Enter the total number of meals by income category (free, reduced, paid) actually served to participants enrolled in all centers.
12. Enter the sum of each meal type.
13. Enter the number of participants enrolled in centers for this claim period by income group.

Free – Enter the number of participants enrolled for which center maintains documentation showing participants eligible in the free category.

Reduced – Enter the number of participants enrolled for which center maintains documentation showing participants eligible in the reduced category.

Paid – Enter the number of participants enrolled for which center maintains no documentation showing participants eligible in the free or reduced category.
14. Complete only if your center is participating/approved in the At-Risk After-School Program.
15. List names of all for-profit centers, total enrollment or licensed capacity for claim period for each center, and the number of eligible Title XX or Title XIX participants or free/reduced eligible in each center.
16. Enter any remarks that you may wish to make.
- 17-19. Must be completed with original signature for payment to be disbursed. Original signature must match signature on application.



STATE OF MISSOURI
OFFICE OF ADMINISTRATION
VENDOR ACH/EFT APPLICATION

SECTION A – TO BE COMPLETED BY THE VENDOR

A VOIDED CHECK OR DEPOSIT TICKET MUST BE ATTACHED. SEE INSTRUCTIONS.

1. VENDOR CODE (11 DIGITS)

2. VENDOR NAME (30 CHAR)

3. VENDOR ADDRESS

CITY

STATE

ZIP CODE

4. ABA ROUTING NUMBER (9 DIGITS)

5. DEPOSITOR ACCOUNT NUMBER

6. DESCRIPTION

7. BANK OR FINANCIAL INSTITUTION NAME

8. BANK OR FINANCIAL INSTITUTION ADDRESS

PHONE NUMBER

9. CITY

10. STATE

11. ZIP CODE

12. TYPE OF ACCOUNT

☐ CHECKING

☐ SAVINGS

13. I HEREBY AUTHORIZE THE STATE OF MISSOURI TO:

- A. INITIATE CREDIT ENTRIES (DEPOSITS) AND TO INITIATE, IF NECESSARY, DEBIT ENTRIES (WITHDRAWALS) OR ADJUSTMENTS FOR ANY CREDIT ENTRIES MADE IN ERROR TO MY ACCOUNT.
- B. TERMINATE MY ENROLLMENT IN THE PROGRAM IF THE STATE IS LEGALLY OBLIGATED TO WITHHOLD PART OR ALL OF MY PAYMENTS FOR ANY REASON.
- C. I UNDERSTAND THAT THIS DOCUMENT SHALL NOT CONSTITUTE AN AMENDMENT OR ASSIGNMENT, OF ANY NATURE WHATSOEVER, OF ANY CONTRACT, PURCHASE ORDER, OR OBLIGATION THAT I MAY HAVE WITH AN AGENCY OF THE STATE OF MISSOURI.

14. AUTHORIZED VENDOR COMPANY SIGNATURE

15. PHONE NUMBER (10 DIGITS)

DATE

SECTION B – FOR STATE OF MISSOURI USE ONLY

I HAVE REVIEWED THE VENDOR INFORMATION FOR COMPLETENESS AND ACCURACY.

AUTHORIZED SIGNATURE

DATE

PHONE NUMBER

Instructions for Vendor ACH/EFT Application:

The Vendor ACH/EFT Application will allow your organization to receive CACFP reimbursement by direct deposit. While it is not required for participation in the CACFP, it is strongly encouraged as it will generally get funds to you slightly faster (no mail delays), and will save you a trip to the bank.

Complete Section A. The vendor number is the number assigned to you by the Office of Administration, Division of Purchasing and Materials Management. Please leave this item blank if you do not know your vendor number (it will be filled in for you by CACFP staff). Item 4, routing number, is printed on the bottom left hand portion of your business checks or deposit tickets (9 digits). Item 5, depositor account number, is printed on the bottom of your business checks following the routing number. NOTE: Check number is NOT included in the depositor account number. PLEASE VERIFY YOUR DEPOSITOR ACCOUNT NUMBER AND ELECTRONIC ROUTING NUMBER WITH YOUR FINANCIAL INSTITUTION. You may leave Item 6, description, blank. Please complete all other items in Section A.

Please leave Section B blank. This section is for State of Missouri use only.

Attach a voided business check or a deposit ticket to the back of the form. This is necessary to verify your account information with your financial institution. Applications without a voided business check or deposit ticket cannot be processed.

Please note that it may take one or more payment cycles for your direct deposit to take effect. In the interim, you will receive your CACFP reimbursement checks through the mail.

If you need to change your Financial Institution or Depositor Account, direct deposit transactions will continue to be deposited into your designated account at your financial institution until the Division of Accounting is notified that you wish to re-designate your account and/or your financial institution. To re-designate, complete and submit a new Vendor ACH/EFT application with the new information and forward to the state agency listed on your original application. PLEASE DO NOT CLOSE AN OLD ACCOUNT UNTIL THE FIRST PAYMENT IS DEPOSITED INTO YOUR NEW ACCOUNT.